

Case Studies in Medicaid Managed-Care

**STATE MEDICAID AGENCIES
AS KEY ACTORS IN
MEDICAID MANAGED-CARE**



Carol S. Weissert



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Nelson A.
Rockefeller
Institute
of
Government

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Carol S. Weissert

*Institute for Public Policy and Social Research
Department of Political Science
Michigan State University*

*For the
Center for Health Care Strategies, Inc.*

**The Nelson A. Rockefeller Institute of Government
411 State Street, Albany, New York 12203-1003
(518) 443-5522 / (518) 443-5788 (Fax)
<http://rockinst.org>**

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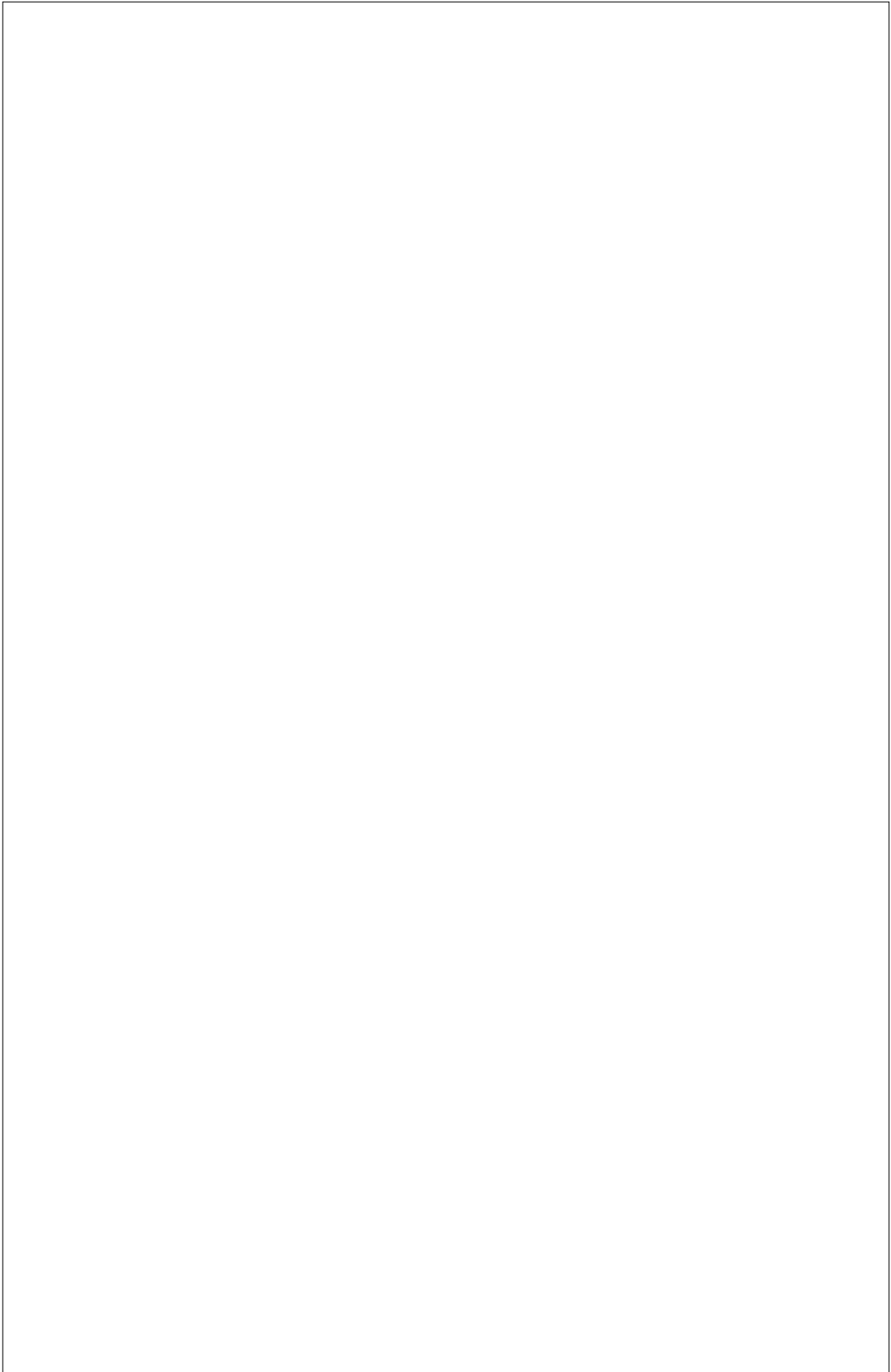
Address inquiries to:
The Nelson A. Rockefeller Institute of Government
411 State Street
Albany, New York, 12203-1003
(518) 443-5522 (phone)
(518) 443-5788 (fax)
cooperm@rockinst.org (e-mail)
<http://rockinst.org> (home page)

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In Brief

This report addresses the following points:

- ❖ Medicaid agencies are important players in public policy formulation and implementation.
- ❖ Governors are natural allies for Medicaid agencies, but they tend to avoid political confrontation.
- ❖ State legislators generally do not understand the complexities of Medicaid and can be persuaded by potent health provider interest groups.
- ❖ “Good relationships” with provider and other health interest groups are necessary, but not sufficient, for success in public policy.
- ❖ The standing or popularity of the Medicaid director does not always translate into political leadership.
- ❖ Medicaid directors must be aware of the importance of political and market conditions in their states and pursue strategies to take advantage of those situations.

Executive Summary

The politics entailed in state Medicaid managed-care decisions have been either ignored or written off as “idiosyncratic” by most researchers. Yet Medicaid agency directors and other practitioners recognize the importance of political influences in developing Medicaid policy. This report seeks to help shed light on the role of political actors in Medicaid managed-care policymaking by analyzing political leadership and lobbying in ten states. Findings indicate that while Medicaid agencies are important actors in formulating Medicaid policy, they are often at odds with state legislators and provider interest groups, who either do not understand the issues or choose to frame them in a way that can undercut state agency positions. Political leadership by Medicaid directors also clearly entails more than simply fostering “good relationships” with the legislature and setting up advisory groups that solicit the input of interest groups. Medicaid directors need to be aware of the importance of political and market conditions in their states and pursue strategies to take advantage of those situations.

State Medicaid Agencies as Key Actors in Medicaid Managed-Care

Anyone who follows state health policy knows that politics are important in administering Medicaid programs. Yet there is a gap between that supposedly common knowledge and more systematic examination of it. A few researchers are beginning to chronicle the pivotal political role state Medicaid agencies play in shaping and implementing Medicaid policy.¹ And there is some recognition of the importance of political environment or political considerations in evaluations and technical reports on Medicaid managed care.² However most analysis of Medicaid managed-care completely ignores its political components.³

This report helps fill this gap by assessing the role of political factors in the development of Medicaid policy — specifically Medicaid managed care — in ten states. The first part of the report addresses five questions:

- ❖ What evidence is there that Medicaid agencies are important actors in state health policy?
- ❖ What is the political context Medicaid agencies face in both their day-to-day activities and in launching and implementing new programs such as Medicaid managed-care?
- ❖ What role does the market context facing health care providers and plans in a state play in launching and implementing new programs?
- ❖ How does Medicaid managed-care differ from other Medicaid issues?
- ❖ What strategies can Medicaid agencies employ to deal with the political aspects of managed care? More specifically, what works where?

This research takes as its starting point a study of ten states from field researchers associated with The Nelson A. Rockefeller Institute of Government. The states include: Arizona, Colorado, Florida, Georgia, Kansas, Michigan, New Jersey, North Carolina, Ohio, and West Virginia. The Rockefeller Institute research associates used a common report form that included a series of questions about political context and efficacy in their states. The reports were completed in January 2000. This information was supplemented with interviews with health interest group lobbyists in five states conducted in March and April 2000.

Situation

1. What evidence is there that Medicaid agencies are important actors in state health policy?

There is some published research documenting the key role Medicaid agency staff play in shaping public policy.⁴ Sparer highlighted the importance of discretion given to Medicaid agencies. Schneider concluded that Medicaid staff are especially influential when issues and choices are highly technical and complicated such as those eligibility guidelines, service decisions, and financing and reimbursement issues that make up the day-to-day activities of Medicaid policy formulation and implementation.

In the ten states studied here, the Medicaid agencies were key players — but not always valued players. In one state (West Virginia), the Medicaid agency had recently been “downsized” and its functions privatized to the point that the researcher characterized it as a hollow agency. In this state, many of the planning functions were carried out by consulting firms. At the other extreme was a larger state (Ohio) whose Medicaid agency appeared to be somewhat arrogant and where legislators complained that they were “talked down to.”

In interviews conducted for this research, health lobbyists recognized the power and importance of the bureaucracy. “They are the ones most involved in the details of implementation,” said

one lobbyist. "They make things happen." Another noted the role the bureaucracy plays in initiating policy. "That is where recommendations or changes are instigated. They go through the governor and on to the legislature." Another said, "Bureaucracy is the day-to-day regular entity. Without their understanding and their ear, very few objectives would be accomplished." Still another lobbyist put it more bluntly, "You've got to ultimately go through them [bureaucrats] to get changes." "The bureaucracy doesn't do anything they don't want to," said a lobbyist.

In sum, state Medicaid agencies are major players in both policy formulation and implementation. They know the rules and the sometimes Byzantine demands from Washington and agency attorneys. But they do not necessarily lead. In only two of the states (Georgia and New Jersey) were agency leaders credited with proposing managed-care. In one state, the change was due to demands for substantial cuts in the program; in the other, it was part of an 1115 waiver proposal to the Health Care Financing Agency that was not submitted.

2. What political contexts do Medicaid agencies face in both their day-to-day activities and in implementing new programs such as Medicaid managed-care?

The political context in which state Medicaid agencies operate encompasses their relationships with the governor, the state legislature, and four types of interest groups: providers, client groups, safety net providers, and plans.

Governors and Medicaid. Most Medicaid agencies in the ten states reported good relationships with the governor. This might have been expected given the importance of Medicaid to state budgets. In only one of the ten states was the governor not supportive of the Medicaid agency. In this state (West Virginia), the agency is fiscally unpopular and distrusted by the governor and legislature alike. In the other states, the relationship was described as "cooperative and generally harmonious" (North Carolina), the governor as "strong and active" in support (New Jersey), and the governor as an "active supporter of the program" (Florida). In several states,

including North Carolina and Colorado, political appointees in state health agencies had the governor's support and trust.

In two states, governors made Medicaid managed-care a plank in their election. In North Carolina, the 1996 gubernatorial candidate (and later governor — Jim Hunt) embraced the managed-care issue (including Medicaid managed-care). He argued that health care should be expanded and managed care investigated as a potential resolution to escalating health care costs, particularly for poor families and children. Both Hunt and his Republican opponent endorsed a Medicaid managed-care pilot program operating in the state's most populous county. (However, Governor Hunt's commitment and interest in Medicaid managed-care waned upon election. Once in office, he devoted his attention to education issues, rather than health, and the pilot program has not expanded to other counties or statewide.) In contrast Georgia Governor Ray Barnes ran on an anti-managed-care platform in 1998 and as a result the state abandoned its full-risk HMO Medicaid managed-care initiative shortly thereafter.

Interviews with lobbyists confirmed the importance of governors in Medicaid policymaking. Interviewees ranked governors as more important than legislators (but less important than Medicaid staff) in implementing the lobbyists' objectives. The importance of governors in general Medicaid decisions on a scale of 1-5, the mean score from lobbyists was 4.0 — compared with 3.9 for legislators and 4.6 for Medicaid staff (see Table 1). However, the governor is less accessible to lobbyists — with a mean score of 3.5 compared to 4.8 for both legislators and Medicaid staff accessibility.

State Legislatures and Medicaid. The relationship between Medicaid, Medicaid agencies and the state legislature is much more mixed. While four of the ten states reported this relationship as good, cooperative or generally harmonious, others reported more difficulties, often associated with costs. In Ohio, legislators have often seen Medicaid as "budget problem," and in West Virginia the relationship between the Medicaid agency and legislators is strained owing to a history of program cost overruns. In other

Table 1. Importance and Accessibility of Policymakers to Lobbyists
Mean Response: Scale 1-5

	<i>Legislators</i>	<i>Governor</i>	<i>Medicaid Staff</i>
Implementing objectives regarding Medicaid programming decisions	3.9	4.0	4.6
Implementing objectives regarding Medicaid managed-care	4.3	4.7	4.3
Accessibility to lobbyists	4.8	3.5	4.8

Source: Telephone interviews with lobbyists from five states. On the scale, 1 represents the lowest level of importance or accessibility and 5 the highest.

states the relationship fluctuates — sometimes good, sometimes bad, often depending on the costs of the program.

It is important to note that state legislators generally are not well-informed on the workings of the Medicaid program. In New Jersey, for example, legislators aren't really "tuned in" to the program and thus provide little oversight or scrutiny. A health committee chair in Arizona confessed that most of her elected colleagues don't know much and care less about the Medicaid managed-care program, and that most, in fact, believe that Arizona does not have a Medicaid program.

Difficulties between an agency and its legislature are no doubt exacerbated by the complexity of the program and the important role played by Washington officials. As one field researcher put it:

It [Medicaid] requires a substantial commitment to invest the time to really understand the program in detail. The legislature has been frustrated on many occasions because they want to move ahead with some sort of simple fix, only to be told that the federal law or rules prohibit the proposed change or make it unattractive. Not only do the legislators not like or understand the program, they resent being lectured to by the Medicaid staff on all the details they don't understand.... In effect, the legislators

interpret the message to be that the huge fiscal commitment (between \$6 billion and \$7 billion per year at present) is a no-choice situation because of federal constraints, which is bound to make the message unpopular.

Despite this complexity, however, in some states, legislatures provide a great deal of oversight to the program and want to school themselves on the details:

- ❖ The West Virginia legislature established an oversight commission on health and human resources that meets monthly while the legislature is out of session.
- ❖ In Colorado, after trying to abolish Medicaid (the measure was vetoed by the governor), in 1996 the legislature established a commission to come up with a remedy for Medicaid's escalating costs. Three years later the legislature set up a health care task force to gather information to formulate legislation, if necessary, for more efficient and effective operation of the health care system in the state, including Medicaid.
- ❖ The Georgia House Appropriations Committee established a special study committee on Medicaid. The committee held sixteen formal hearings across the state and issued a report which dealt with Medicaid provider reimbursements, fraud and abuse and the "hassle factors" experienced by providers dealing with the Division of Medical Assistance (DMA). The report called for a more "realistic" approach to setting reimbursement rates and for more open communication between providers and the state's Medicaid agency. The issue of Medicaid managed care was not specifically addressed in this report.

In some states, legislative oversight is longstanding. For example, in North Carolina, the General Assembly is where the "real power in North Carolina politics is located," according to that state's field researcher. Sometimes the legislative role is affected by scandal or other salient issues, such as in Florida where newspaper

accounts of questionable tactics in marketing Medicaid managed-care plans to recipients led to increased legislative scrutiny.

However, in other study states — Arizona, Michigan, New Jersey, and Ohio — the legislature does not provide active oversight of state Medicaid programs.

The lobbyists interviewed for this research emphasized the differences in the roles of the legislature and the bureaucracy. As one lobbyist put it, “We lobby the legislature when there is an important issue.” Another put it this way: “Programming decisions are made at the department level. The General Assembly gets broader topics.” Another noted that the legislature tends not to become involved with implementation issues, except for halting unwanted or unanticipated measures. For example, in Michigan, the plans complained to the legislature that the Medicaid managed-care contracts did not adequately cover the costs of maternal and child care and transportation; providers and children’s groups have argued that immunizations are not being adequately provided.

The legislature also controls the state spending — a role extremely important to lobbyists. “We must establish (desired) funding levels (in the legislature),” said one lobbyist. “The legislature controls the purse strings. They determine how much money Medicaid will get,” said another. In some states interest groups worked closely with the Medicaid agency to lobby the legislature on these issues; in most states they did not — often “going around” the state agencies to seek more funding than that supported by the agency and the governor.

In sum, legislators’ relationships to Medicaid agencies were often defined by rising (often called “skyrocketing”) Medicaid costs. Few legislators understand Medicaid but this does not keep them from setting up commissions and task forces and holding hearings — particularly in response to rising Medicaid costs and complaints from health care providers.

Interest Groups. Providers — specifically hospitals and physicians — are typically potent political actors in states.⁵ They also appear to strongly influence the design and implementation of Medicaid managed-care. In over half of the ten study states, survey respondents and interviewees described the relationship between the Medicaid agency and provider associations as established, collegial, and cordial. A number of the states include representatives of provider groups in monthly meetings with Medicaid agency staff. However, in most states, this relationship fluctuates largely with reimbursement. When the agency or legislature proposes cuts in funding, rifts can easily arise.

For example, the field researcher in Ohio reported that “payment issues dominate the relationship.” In Colorado, the relationship between the agency and physicians and hospitals was described as “on the rocks primarily due to past rate cuts and more proposed rate cuts.” In Georgia, a long and harmonious relationship was disrupted when the governor directed the agency to find savings in Medicaid, often from providers. When new agency leadership came in with a new governor and provided more money, the general harmony resumed.

In several states (Georgia, West Virginia, Colorado and North Carolina), physicians are the dominant force in Medicaid policymaking. These relationships benefit both agency and providers. For example, in North Carolina, top health department leaders are physicians. As evidence of the strong ties this relationship represents, provider-controlled plans called for oversight by the health agency, not the usual insurance department.

Hospital associations are strong in several states and in at least two states led the opposition to managed-care, blaming hospitals’ financial problems on managed-care. In Michigan, the hospital association (joined by their physician counterpart) loudly and forcefully blamed hospital closures on Medicaid managed-care (although a legislative staff report severely undercut these assertions). In West Virginia, some hospitals also pointed to Medicaid managed-care as directly harming their mission. (One hospital

official complained to a legislative hearing that the facility had been frozen out of contracts and might sue.)

Overall, the provider associations were major players to be reckoned with, and most Medicaid agencies strove for good relationships with them. (Again, the exception is Michigan where the health department director battled the hospital association via press releases and confrontations before legislative committees.)

When asked about whether their relationship with the Medicaid agency was amicable (on a scale from 1 to 5), health lobbyists responded positively, with a mean score of 4.2. However, this mean score was greatly affected by the situation in one state whose lobbyist ranked the relationship as 2.0, reporting, “more often than not [Medicaid staff] have been an adversary as much as an ally.” Without this lobbyist’s response, the mean rises to 4.6.

Medicaid agencies’ relationships with one special subset of providers — those providing the “safety net” to the state’s poor — is more mixed than that with more established hospital and physician groups. While a number of states tried to “protect” these providers in their contracts by encouraging or mandating plans to use them, the ability of these providers to function with low rates and in rural areas is still a concern in many states. Several Medicaid agencies have reached out to encourage federally qualified health centers (FQHCs) to participate in managed-care — but with mixed results. In New Jersey and Michigan safety net providers successfully marketed themselves to HMOs or qualified health plans participating in the Medicaid managed-care program. However, in Ohio, one of the largest safety net providers is pulling out of the program. Collaborations have been difficult for these providers in several states in part because the FQHCs have special status in Medicaid thanks to federal law. Florida Medicaid staff attribute their lack of success with these groups to the “insulated nature” of the FQHC environment in which their budgets are assured and “red ink” is covered by taxpayers.

The ten states reported the relationships between Medicaid agencies and advocacy groups representing clients as cordial, if

rather formal. This finding is surprising given the expected distrust by these groups regarding the movement to managed-care, almost universally attributed to the desire to cut costs. The finding can best be understood in two ways. First, Medicaid agencies, including the one in West Virginia, apparently have reached out to client advocacy groups in designing and implementing managed-care. Field researchers in every state reported efforts by state agencies to encourage feedback from advocacy groups on the transition to managed-care and many groups have close working relationships with the agency.

A second reason might be dissatisfaction with the previous system and hope that managed-care will bring improvements. In New Jersey, for example, client advocacy groups have been very positive about the state's Medicaid managed-care program owing to their dissatisfaction with the previous system. In this state, advocacy groups approve of the state's low auto-assignment rate, strong quality assurance measures built into contracts, and the gradual implementation of Medicaid managed-care. Only one state (Georgia) reported concerns by advocacy groups, and there the Medicaid agency did encourage their feedback and help in designing the new system.

Finally, Medicaid agencies' relationship with plans that enroll clients is mixed. Some states (New Jersey, West Virginia, and Colorado) report good or fairly good relationships. New Jersey reported a "solid give and take of information and regular meetings between the head of Medicaid and the CEOs of the plans." Other states report a strained (Ohio) or adversarial relationship (Georgia). Ohio health plans felt that the Medicaid agency simply did not understand the financial realities of running a managed-care plan. In this state, the plans did not have the ear of the legislature, which listened more intently to the provider community, particularly to the economic development arguments of the hospitals (that cuts would result in loss of local jobs). In Georgia, where the Medicaid director regularly courts physicians and hospitals, the relationship between the agency and the HMOs was described as adversarial. The latter think rates are low but have not been successful in

increasing them. In West Virginia, a good working relationship between the Medicaid agency and participating plans relies on informal channels of communication — especially easy in a small state with very few plans.

Arizona has seen little friction between plans and the program because disputes over payments have been minimal. Providers and home-grown plans work together to lobby the legislature on managed-care issues and are also intent on working with the agency. In Michigan, as vocal battles between the state Medicaid agency and physician and hospital groups played out in the media, the association of health plans worked quietly with the state agency and the legislature to win higher reimbursements and changes in the original contracts. The relationship between Medicaid agencies and “established” providers is very different from that with newer organized health plan interests. In West Virginia, the plans are not well-known by legislators or others — even legislators from the counties served.

In sum, relationships between state agencies and the governor and client advocacy groups were generally positive over the ten states. The relationships were less consistent between Medicaid agencies and state legislatures, providers, and plans. Provider groups, particularly, work well with Medicaid agencies until cuts are made in payments, the groups then seek relief from the legislature — where their success is far from guaranteed. Legislators reported mixed relationship with plans but did not cite the high-visibility “hard ball” tactics of provider groups, which have usually been political players in the state for decades.

3. What role does the market context play in launching and implementing new programs?

The short answer is that both market and political contexts are important and the market context should help shape the political situation (the reverse, that the political situation shapes the market context also applies in other venues but is not terribly persuasive here). There is empirical evidence that the market does affect political activities. In a study of actions of state medical boards,

Weissert and Silberman found that the HMO penetration in the state encouraged state legislators' involvement in state medical board policy-related decisions and activities.⁶

The market context of Medicaid managed-care can be measured in a variety of ways. The traditional measure — the penetration of (private) managed-care plans — may not be the best measure since other issues such as the availability of plans across a state are also key. Some states, such as Georgia, report substantial commercial managed-care coverage (37 percent of market share in July 1999), but this market is concentrated largely in metropolitan areas. The Medicaid program in Georgia relies solely on primary care case management, not a full-risk model.

Some private plans were reluctant to participate in Medicaid managed-care because of low reimbursement rates or potential stigma. However, in two larger states in the study the plans were much more responsive. Interestingly, only two states reported special incentives to attract plans. Most provided no special arrangements, relying instead on the market to encourage plans to participate.

States' history of involvement in Medicaid managed-care might provide a better measure of the market. As early as 1978, Ohio was attempting to expand managed care, and by the mid-1980s, had established a state office to develop HMO experiments. Michigan and Florida were also early entrants into Medicaid managed-care. In contrast, West Virginia, Georgia, and Colorado were new to Medicaid managed-care — discovering it, largely as a cost-control tool in the mid-1990s.

As a way to help clarify the relationships, the political and market environments can be capsulated into a matrix using one measure of political values and one measure of market values. Figure 1 illustrates the matrix using as the market environmental variable whether Medicaid managed-care is longstanding or relatively new. The political variable is the legislative role in overseeing the Medicaid managed-care program.

Figure 1		
Political Environment		
	<i>Strong Legislative Oversight</i>	<i>Weak Legislative Oversight</i>
Experience in Medicaid Managed Care	Florida	Arizona, Michigan, New Jersey, Ohio
Market Environment		
Little Experience in Medicaid Managed-Care	Colorado, Georgia, North Carolina, Kansas, West Virginia	

As expected, most of the states fall on the diagonal: states where managed-care involvement is longstanding and where there is little legislative oversight, or where managed-care involvement is newer and legislative involvement is strong. Only one state (Florida) is off-diagonal. Florida's position can be explained by a "scandal" involving seemingly unscrupulous activities to sign up clients exposed in newspapers that led to stepped up legislative oversight during the study period.

While Figure 1 does not imply cause and effect, it is probably the case that where Medicaid managed-care is established in the state, the legislative role is likely to be reduced. Arizona is an excellent case in point. In setting up the nation's first Medicaid managed-care system in the early 1980s, the legislature worked hand-in-hand with the governor. Over time, the legislators who helped create the system left the legislature, but the Medicaid agency continues to maintain a good relationship with the legislature. Because it is a more mature program, it does not need the kind of intense support that it required in the beginning.

The matrix can help us understand the dynamics between market and politics and suggest strategies for action. States with a history in Medicaid managed-care and little legislative oversight can make major changes in the program without legislative involvement (or interference). While interest groups may be strong in these states, they may not be as successful at lobbying the

legislature as in other states. In fact, in one of these states, Arizona, the Medicaid agency works with interest groups to form a united front in lobbying the legislature.

In contrast, states where the legislature exerts more “micro-management,” and where Medicaid managed-care does not have a track record, will likely need more cooperation with (or even capitulation to) interest groups, which can easily go to the legislature. Without a base of support or a history to fall back on, the Medicaid agency is more dependent on both interest groups and the legislature for support. The agency may thus spend more time on building and maintaining political support, than on developing new programs or expanding old ones.

4. How does Medicaid managed-care differ from other Medicaid issues?

This analysis examined two subsets of Medicaid policy — specific Medicaid issues such as rate setting and more generally the transition to Medicaid managed care. We did find some differences in both strategies and relationships between the two types of policies. Even for states prone to legislative involvement and manipulation by interest groups, routine rate setting, coverage, and support were not subject to major legislative or public oversight. More general managed-care issues, which often combine national publicity with home-grown “horror” stories, are more likely to make the local news and be the subject of town-meeting gripe sessions.

The differences were clear in interviews with lobbyists in five states: the mean importance of the governor jumped from 4 to 4.7 (on a scale of 1 to 5) on Medicaid managed-care compared with general Medicaid issues. The mean importance of the legislature increased from 3.9 to 4.3 (see Table 1). In contrast, the importance of the bureaucracy reflected in the mean dropped from 4.6 to 4.3. Thus, as expected, a more salient issue draws in political leaders more readily than the less salient, more complex, routine Medicaid policymaking.

The strategies used by lobbyists also varied with the issue. Lobbyists valued legislative support more highly as a strategy in

managed-care decisions — rising to 4.3 from 3.9 in more routine Medicaid matters. The importance of media also increased between more routine matters and Medicaid managed-care — from 3.4 to 3.6. The importance of having friends in the bureaucracy and participation in task forces declines slightly in managed-care decisions compared with more routine Medicaid issues.

5. What strategies can Medicaid agencies employ to deal with the political aspects of managed-care? More specifically, what works where?

Recognizing the importance (and differing roles) of the state legislature and the state's health interest groups, Medicaid agencies in the study states adopted different strategies for working with these constituents. However, they were generally more successful in dealing with the interest groups than with their state legislatures.

All the state Medicaid agencies sponsor regular meetings with providers and health plans. Many states commonly use committees, task forces, and advisory groups to gather information, win over unhappy groups and citizens, and serve as a useful symbol of "reaching out." Florida regularly includes advocacy groups in its strategy and information sessions. Arizona supplements such interaction with regular surveys and focus groups. Kansas holds forums with interest groups.

Field researchers described these strategies as taking three forms: collaborative (especially in Kansas and Georgia); consultative (especially Florida, Colorado, and Ohio); and co-optative (in Arizona).

In the collaborative model, the state Medicaid agency uses monthly meetings with hospital and physician groups and plans, often in separate sessions, to discuss both policy and operational issues. The latest Washington directives, state responses, and progress reports on implementation are all common topics of discussion across the states using this model. In Kansas, providers participate with the agency in two different monthly meetings that serve as a forum for many operational issues. Kansas also holds

monthly meetings with local health departments. However, the agency goes alone to the legislature on rate issues.

The consultative model is similar but relies on a clearer hierarchical ordering. In Florida, Michigan, and Colorado the state agency uses sessions for information but maintains a clear distinction between the agency and the groups. The model entails less partnership and more information sharing. In these states, interest groups feel free — and do — lobby against the state agency for more funding to provide other issues.

In Ohio, the agency has used a local “hands-on” approach to turn those interest groups to the agency’s advantage. Ohio’s Medicaid agency meets regularly with county-level plans in counties with full-risk managed-care. These special advisory councils act as sounding boards for immediate operational issues but are also more influential than more “policy-oriented” statewide consultative groups. For example, the county groups are quite active in responding to requests for comments on proposed rules and in meeting with state officials and legislators to talk about the implementation of Medicaid managed-care. The councils enhance their effectiveness by providing real-world examples and naming constituents affected by enrollment problems, consumer hotline delays, or loss of providers in a way aggregate numbers simply cannot. This is an example of the “I know a man” theory at work. Coined by William Browne, the theory posits that legislators relate most directly to personal situations.⁷

Arizona’s co-optation model appears to be the most successful in dealing with the legislature. Arizona’s Medicaid program (Arizona Health Care Cost Containment System or AHCCCS) works closely with external actors through regular meetings, committees, and focus groups. Many state agencies do this. But AHCCCS also works with these groups to form a united front on Medicaid issues. As a result, providers have never gone directly to the state to lobby on managed-care issues. AHCCCS and plans have also worked together to lobby the legislature on managed-care issues. At least some of AHCCCS’s success may stem from its clear mission to contain costs — witness its name. With this

mission clearly articulated, the agency then works with the provider groups and plans to fulfill its assignment. The legislature believes it has contained costs, and everyone is happy.

These strategies, while important, may be viewed as necessary but not sufficient since these relationships may not translate into improved legislative relationships and the desired policy changes. For example, in Ohio, the agency's efforts at building external constituencies did not produce a good relationship with the legislature. The agency did not explain the program well so legislators were eager to blame the agency when plans pulled out and hospitals closed. Agency communications with the *legislature* are thus also important.

Georgia informs us that consultation must be ongoing — and works best when times are good and cuts are not in the offing. Until the mid-1990s, Georgia's executive and legislative leaders were intent on keeping providers happy. As a result the program, until the early 1990s, experienced enormous growth through categorical expansions and a series of rate increases for providers. However, in 1993, when Medicaid was facing cuts, the relationship with providers became much more strained. Medicaid was closely examined by a citizen board and the legislature, which set up a special committee and held a series of hearings. By 1998, under new gubernatorial leadership and an easing of state budgetary problems, cordial relationships reemerged. According to the Georgia field researcher, the state now "wishes to make provider relations a cornerstone of their managed-care efforts and appears to be reestablishing their connection to and concern for providers ... DMA wants to be a "partner" to providers and help them in their efforts to become more involved with Medicaid patients." The Medicaid director attends the state medical society's annual meetings and has established an advisory group of physicians to provide input on reimbursement, paperwork, and other obstacles to serving Medicaid clients. The director serves as an advocate for providers and recently spearheaded an effort to win them an increase. The lesson is that relationships can turn sour when provider groups

feel disadvantaged, but they can easily be rekindled when the “money” returns.

In Michigan, cooperative long-term relationships dissipated only a few years into the state’s “fire, ready, aim” strategy for moving to statewide full-risk managed-care. The state was a pioneer in the primary care case management (PCCM) model, under which Medicaid recipients select a primary care provider who is their required contact person with the medical delivery system. But by the mid-1990s, the state decided to move dramatically to a full-risk model covering 700,000 beneficiaries statewide. The plan entailed two stages within a short time-frame. The first stage, launched in 1997, involved five counties in southeast Michigan, the most populous part of the state and where HMO penetration was the highest. The second stage, launched a year later, encompassed the remaining seventy-eight counties in the “outstate” area, where HMOs were often not in place.

Michigan’s providers and plans were initially willing to go along with the state’s proposed changes in part, according to one observer, thanks to a longstanding positive relationship with the Medicaid agency. The plans were also supportive because they realized that Medicaid managed-care offered the potential for expanding their market share and ability to make money off public clients. Even with somewhat lower payments, existing plans felt they could participate through large volume, especially in the populous areas around Detroit. The fact that the HMOs were all home grown no doubt helped cement this cooperative stance.

But the relationship soured when the state deposited \$120 million in savings in the southeastern Michigan in the state general fund while keeping provider payments relatively low. While payment levels for plans involved in the outstate area were higher (and the state reaped no windfalls), the ill will continued and played out in the legislature. Arguments over provisions in the contracts made their way into language in appropriations bills. Legislative hearings became the place for name-calling and inflammatory language between state Medicaid leaders and provider representatives with the plans playing a more neutral role. The

lesson from Michigan, then, supports that of Georgia. When cuts loom, the relationship between agency and plans and providers — even one built on years of trust — can quickly dissolve.

Lobbyists confirmed their preference for this type of involvement. A telephone survey of lobbyists asked them to rank on a scale of 1 to 5 the usefulness of several possible lobbying strategies: legislative support, direct access to the bureaucracy, friendships with Medicaid staff, participation in task forces, and media coverage. Direct access was ranked highest with a mean of 4.4, much in keeping with the literature on federal and state lobbying. Legislative support of an issue was also an important component (with a mean of 3.9), as were friendships with Medicaid staff (3.8). Unlike Washington, where the size and scope of government probably prohibits long-term friendships, in many state capitols Medicaid agency staff are neighbors and friends with lobbyists, and sometimes lobbyists become state agency staff and vice versa. In one typical situation, a top Medicaid staffer co-owned a vacation house with a top health lobbyist.

Overall, coordination and involvement with interest groups seems to be the most popular strategy among state agencies. However, co-optation, à la Arizona, may be the most ideal. Bringing external constituencies and the agency together to lobby the legislature in a united front leaves little room for “divide and conquer” strategies in which groups go to the legislature to get what they cannot from agencies. In Michigan, this strategy worked — but only marginally — for the providers and plans while engendering a great deal of ill will that persisted for years after the initial legislative efforts and media play.

Challenges to Address

Even savvy Medicaid directors find exerting political leadership difficult. Most problematic is convincing interest groups to join the agency in presenting a united front to the legislature. In the ten study states, this occurred only in Arizona — the state with the longest Medicaid history and a legislature that gives the agency

minimum oversight. Several states adopting the collaborative and consultative approaches found that relationships with interest groups (and legislators) are good when reimbursements are satisfactory. But when cuts have to be made, longstanding relationships easily fray. In one state (Michigan), relationships remained secure for a short time, but providers then went to the legislature and launched a visible battle with the agency. In Georgia, the Medicaid agency attempted mightily to retain support, but when market forces led to the need to reduce rates, the partnership immediately disintegrated (only to be rekindled when the providers once again received the funding they wanted).

Keeping overall Medicaid costs down while keeping providers and plans happy seems to be a juggling act that only Arizona has mastered, in part because the state's Medicaid coverage is still rather limited. Only residents whose income is at or below 32 percent of the federal poverty line qualify for Medicaid. However, recognizing the challenge of containing costs while retaining allies is key.

Also important is understanding political dynamics which include the following four lessons:

1. The "I Know a Man" theory is important in legislative relations.
2. No one likes controversy, especially elected officials.
3. Agencies need to enlist allies and information sources in other state agencies.
4. The standing or popularity of the Medicaid director does not always translate into political leadership.

The Ohio example of using real people (constituents) and real situations (rather than abstract analysis) to lobby the legislature illustrates the importance of the "I Know a Man" theory. Hospital administrators and physicians have been doing this effectively for some time. It is more difficult for state officials who rarely see patients or clients. An intermediary group can serve this purpose with the legislature.

Political science research tells us that even when only one person or group opposes a policy or bill, the odds of passage drop substantially. Legislators (like most people) don't like controversy. Arizona uses this notion effectively in presenting a united front to the legislature. Michigan provides the opposite case: controversy was everywhere, and the legislature ended up making no one perfectly happy while creating ill will in the process.

Medicaid agencies need to look for allies in other state agencies or bureaus. Michigan's non-partisan Senate Fiscal Agency conducted research that undercut the hospitals' allegations that Medicaid managed-care had created major financial problems across the state. The fiscal agency has a great deal of credibility in the capitol and quietly helped influence the debate while supporting the Medicaid agency in the process.

A final lesson relates to political leadership. Political leadership is difficult and not necessarily related to the standing or popularity of the agency director. While several Medicaid agencies were headed by former legislators or high-ranking state officials close to the governor, the political experience of these leaders did not noticeably enhance their agencies' prospects. Several field researchers reported that Medicaid directors were respected but that the respect did not accrue more broadly to the agency. In Ohio, the Medicaid director was well-liked and known as a good communicator, but constituents felt that he set no coherent policy direction, and he was thus unable to rally the external constituency.

Recommendations

Overall, the results of this study and these lessons yield five central recommendations:

1. Consultation and cooperation are useful means of enhancing the positive contributions of interest groups, and can help the program succeed. However, consultation and cooperation must be viewed as necessary, but not sufficient.

2. Positive relationships between agencies and state legislators are crucial but can be very difficult. It is not enough for Medicaid directors to have friends in the legislature. They also need to provide solid, usable information, to refrain from “talking down” to elected officials, and to develop local ties, including to people who can share real stories and problems with legislators. Particularly useful are relationships with committee chairs and other legislative “attentives” who will play the largest role in Medicaid policy. They will be eager to understand the program and participate in shaping and refining it. Other legislators will not.
3. Information can be useful. Michigan’s Senate Fiscal Agency investigated allegations against Medicaid managed-care by a strong provider interest group and found the evidence supporting the allegations lacking. The legitimacy of these arguments was enhanced by the high status (and nonpartisan nature) of the report’s authors.
4. Interest groups are not endowed equally and probably should not be treated equally. While most interest groups like to be consulted, established provider groups have access to a political base and to the media, giving them special status. They are also substantial contributors to legislative and gubernatorial campaigns, giving them additional political standing.
5. Gubernatorial support is key and is generally forthcoming. However, some governors provide their support primarily through their appointees. Others choose to use their own political capital to promote the program. But all tend to stay out of battles with providers over payment issues.

Next Steps

Among Medicaid agencies in different states more sharing of strategies for dealing with interest groups (particularly providers) and legislatures is key. While one strategy will not necessarily work in

every state, agencies can adjust their approach to fit the state's political and market environment. While different in many respects, legislatures also share many political tendencies, such as the desire of legislators for reelection and an aversion to controversy.

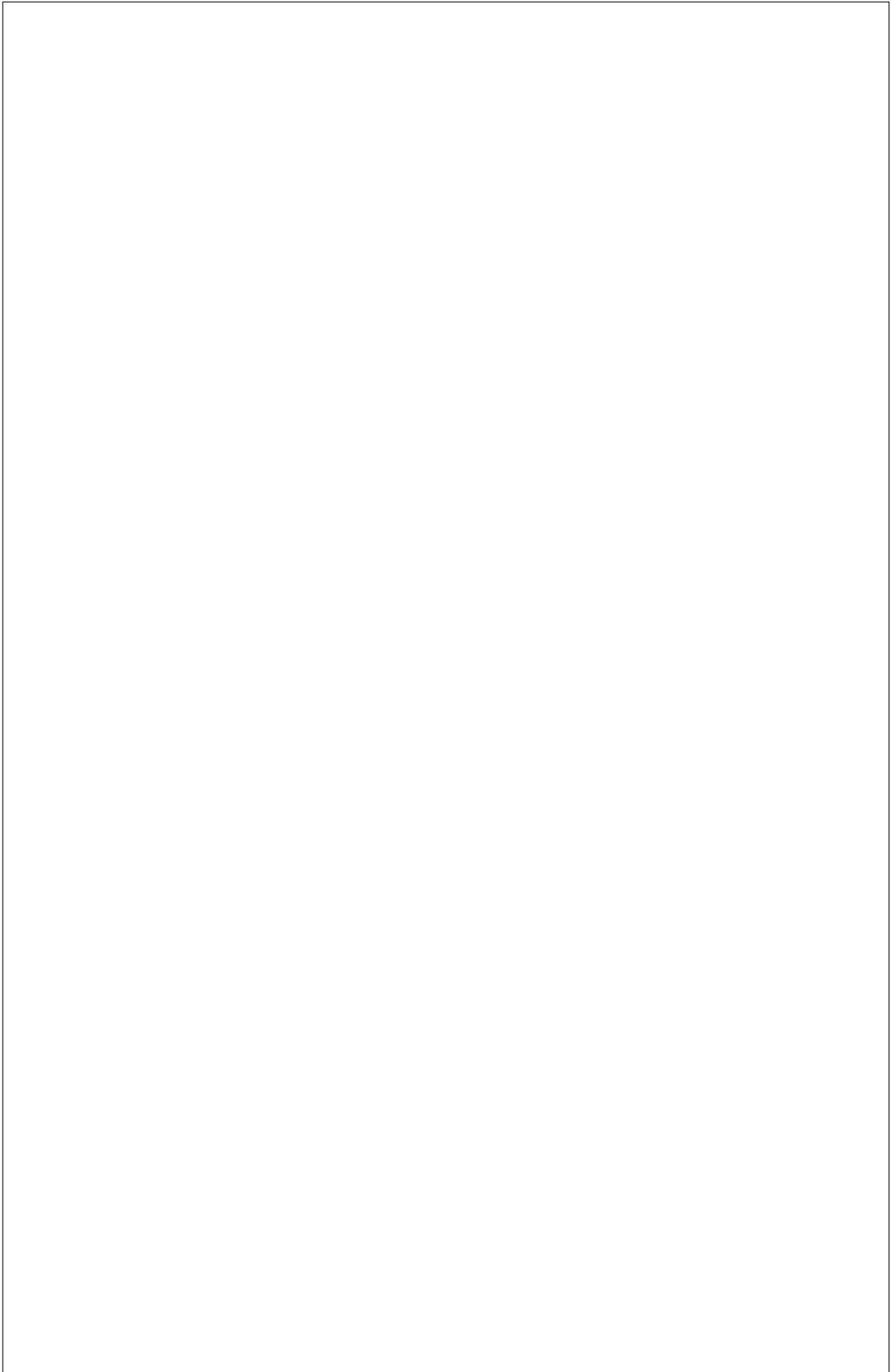
Agencies need to recognize that information is important to political success, and that information will not necessarily come from the Medicaid agency. Analysis by national associations, academic researchers, state legislative staff can be persuasive to legislators and help counter information that presents only one side of the case.

Additional training for Medicaid agency leaders also might prove useful. Experience as a former state legislator or state official will not give a director the tools to effectively lead state Medicaid agencies. Medicaid leaders need to develop missions, strategies and, above all, create a vision to guide discussions and decisions. Seminars and online material, along with case studies of successful leaders in other highly visible and controversial positions might prove useful to Medicaid directors. Among the most successful offerings of the National Governors' Association are the New Governors Training Sessions which pair new governors with sitting governors who share both big and little secrets of the trade. Such an exchange might also be useful to new (and old) Medicaid directors.

In short, the world of Medicaid directors is a political world that is difficult but not incomprehensible. Two key but highly volatile constituencies are provider (and to a less extent plan) groups and the state legislature. Simply calling regular meetings with these external constituencies and testifying at legislative hearings to win them over is not enough. A deeper understanding of legislative decisionmaking and the importance of working with, but not for, provider groups is also essential.

Endnotes

- 1 See, for example, S. K. Schneider, W. G. Jacoby, and J. D. Cogburn, "The Structure of Bureaucratic Decisions in the American States," *Public Administration Review* 57 (3) May/June 1997, pp. 240-249; S.K. Schneider and W. G. Jacoby, "Influences on Bureaucratic Policy Initiatives in the American States," *Journal of Public Administration Research and Theory* 6 (4) October 1996, pp. 495-522; T. Oliver, "The Collision of Economics and Politics in Medicaid Managed Care: Reflections on the Course of Reform in Maryland," *The Milbank Quarterly* 76 (1), March 1998, pp.59-101.
- 2 M. Gold and J. Mittler, "Medicaid's Complex Goals: Challenges for Managed Care and Behavioral Health," *Health Care Financing Review* 22 (2), Winter 2000, pp. 85-101; M. Gold and J. Mittler, "Second-Generation" Medicaid Managed Care: Can It Deliver," *Health Care Financing Review*, Winter 2000.
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- 6 C.S. Weissert and S. Silberman. "Legislative Demands for Bureaucratic Policymaking: The Case of State Medical Boards." *Legislative Studies Quarterly* XXVII (1), February 2002, pp. 123-139.
- 7 W. Browne. "Group Leaders, Grassroots Confidants, and Congressional Responses." Paper presented at the annual meeting of the Midwest Political Science Association, Chicago, April 6-8, 1993.





**The Nelson A.
Rockefeller
Institute of
Government**

411 State Street,
Albany, New York
12203-1003

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